Franklin County Fire-Trax Accountability System Fire/EMS/Municipality Form

ID# (Last Four Numbers of SS #) _____ Date Completed _____

Department Affiliation _____

First Name _____ Last Name _____

DOB _____

FD/EMS Position: (circle one) FF FF/EMT FF/Paramedic FF/EMR Fire Police Jr Member
EMT Paramedic Driver

Municipality: EMA Coordinator Supervisor Deputy EMA Assistant EMA Employee

Initial Hire Date (Paid or Volunteer) _____

Emergency Contact Name _____

Emergency Contact Address _____

Emergency Contact

Primary Phone # _____ Secondary Phone # _____

Allergies:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Medical History (circle any that applies)

1. Diabetic
2. Breathing problems
3. Heart related conditions
4. Hypertension

FIRE/EMS/MUNICIPAL DEPARTMENT WILL KEEP A COPY FOR THEIR RECORDS.

I HEREBY AUTHORIZE THE DEPARTMENT OF EMERGENCY SERVICES AND OTHER NECESSARY MEDICAL PERSONNEL TO VIEW MY MEDICAL INFORMATION.

SIGNED BY: DATE: